WORKERS COMPENSATION PROTOCOLS
WHEN PRIMARY INJURY IS PSYCHIATRIC/PSYCHOLOGICAL

General Guidelines

Patient must have a diagnosed mental illness on Axis I as defined by DSM-IV that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. The emotional impairment must be of such a degree to severely interfere with social, familial, or occupational functioning.

For the purpose of determining medical necessity of care, medical necessity is defined as "Services and supplies by a provider to identify or treat an illness that has been diagnosed." They are:

A. Consistent with the efficient diagnosis and treatment of a condition, and standards of good medical practice.
B. Required for other than convenience.
C. The most appropriate supply or level of service.
D. Unable to be provided in a more cost effective and efficient manner; and
E. Unable to be provided elsewhere by a less intensive level of care.

The evaluation and assignment of mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by a psychiatrist or doctoral level clinical psychologist.

Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV codes on all axes (I-V), using published criteria.

Whenever feasible and appropriate, psychiatric care and treatment should take place in an outpatient setting or the less intensive treatment setting able to meet the patient's needs. Structured outpatient programs are considered the treatment of first choice. Inpatient treatment is considered medically necessary when all less intensive levels of treatment have been determined to be unsafe or have been unsuccessful.

The initial evaluation should include not only documentation of the diagnosis (DSM-IV, axes I-V) but also an initial treatment plan, individualized goals for treatment, treatment modalities to be used, and discharge planning.

A progress note documenting the provider's treatment, the patient's response to treatment, and the persistence of the problems that necessitate continued care despite treatment efforts, with the emergence of additional problems consistent with the initial diagnosis, must be written for each session of treatment. Documentation of disposition planning should be an integral part of each session note. Response, non-response or severe reactions to medications given must be recorded.

ADULT PSYCHIATRIC HOSPITALIZATION CRITERIA

Medical necessity of psychiatric inpatient admission must be documented based on conditions defined under either Section I or Section II.

I. Criteria for Admission Based on Severity of Illness.

A. Patient makes direct threats or a reasonable inference of serious harm to self or to the body or property of others.

B. Violent, unpredictable or uncontrolled behavior, including patients with organic brain impairment and/or functional illness.

C. Lack of insight, unwillingness or inability to adequately care for one's physical needs. Acute cases may include starvation or failure to take essential medications accurately and safely.

D. Lack of response to previously attempted partial hospitalization management of medication and/or psychotherapy.

II. Criteria for Admission Based on Intensity of Service.

A. Need for daily skilled observation by both MD and RN staff(such as, but not limited to):

(1) To confirm diagnosis;
(2) To initiate medication regime;
(3) To regulate dosage of potent medication; or
(4) To withdraw potent medication.

B. Need for electroconvulsive shock therapy.

III. Criteria for Continued Stay.

The treatment plan should include documentation of diagnosis, individualized goals of treatment and therapeutic modalities. The medical record must include daily progress notes by the psychiatrist or psychologist.

While documentation may justify the need for continued hospitalization, the Medical Advisory Board expects that each service rendered by a physician or other provider of care and reported for payment be documented in the medical record. Documentation should include:

A. The persistence of the problems that necessitated the admission, despite therapeutic efforts, or the emergence of additional problems consistent with the admission criteria.

B. Severe reaction to the medication or need for further monitoring and adjustment of dosage.

C. Attempts at therapeutic re-entry into the community have resulted in exacerbation of the psychiatric illness.

D. Psychiatric evidence or rationale indicating the need for stabilization of patient's condition to a point where stress of community re-entry does not substantially risk an exacerbation of the psychiatric illness.

HOSPITALIZATION CRITERIA FOR SUBSTANCE DEPENDENCY

(Applies to Psychiatric Hospitals and General Hospital Psychiatric Units)

Admission to a psychiatric hospital is appropriate for alcohol and/or drug dependency of a severity which requires intensive intervention by a multi-disciplinary health care team including physicians, nurses, counselors, social workers, and other therapists. Evidence should be present that outpatient care or treatment in an intermediate care facility has been attempted recently, but has been unsuccessful.

The patient also must have, in addition to substance dependency of a severity described above, a psychiatric disorder which inhibits his/her ability to be treated in a less intensive setting. There must be documented evidence of a present and acute psychiatric disorder of a severity which would require hospitalization in and of itself in accordance with the Adult Psychiatric criteria.

I. SUBSTANCE DEPENDENCY CRITERIA FOR REHABILITATION SERVICES FOR ADMISSION.

Patient needs to meet the Adult Psychiatric Admission Criteria and both of the admission criteria given below.

A. Patient has alcohol and/or drug dependency of a severity which requires intensive intervention, at a hospital level of care, by a multi-disciplinary health care team including physicians, nurses, counselors, social workers, and other therapists. Evidence that the patient cannot be treated in a residential center for substance abuse must be documented.

B. Patient has, in addition to substance dependency of a severity described above, a psychiatric disorder which inhibits his/her ability to be treated in a less intensive setting. Evidence of a present and acute psychiatric disorder of a severity which would require hospitalization in accordance with the adult psychiatric criteria must be documented.

II. CRITERIA FOR CONTINUED STAY

The patient needs to meet the Adult Psychiatric Continued Stay Criteria, as well as (all of) A through D below.

A. The treatment plan should include documentation for both the substance dependency and psychiatric disorders of individualized goals of treatment and therapeutic modalities.

B. The medical record should include daily patient's progress notes by the psychiatrist, psychologist, or primary therapist. Evidence should be presented as to whether or not the problems necessitating admission have changed in response to specific treatment modalities being utilized.

C. Documentation of all therapeutic modalities being provided to the patient on a daily basis should be present and should specify the plan of treatment and patient's progress.

D. Post-hospital treatment planning and referral efforts that have been conducted as soon as the initial evaluation is complete must be documented in the treatment plan and progress notes.

RESIDENTIAL TREATMENT CRITERIA FOR SUBSTANCE ABUSE

I. CRITERIA FOR ADMISSION.

Medical necessity for admission to a residential substance abuse treatment facility must be documented by the presence of all of the criteria below in Section A and Section B.

In addition, it is noted that structured professional outpatient treatment is the treatment of first choice. Residential treatment, when indicated, should (a) be individualized and not consist of a standard, pre-established number of days, and (b) should follow recent outpatient treatment in a structured professional program of significant duration and intensity during the course of which the patient has not been able to maintain abstinence for a significant period of time.

A. Severity of Need.

1. The provider must be able to document that the individual has a history of alcohol/substance dependence but is mentally competent and cognitively stable enough to benefit from admission to the inpatient program at this point in time. Individual days during any part of the stay where the patient does not meet this criterion cannot be certified as medically necessary.

2. Individual exhibits a pattern of severe alcohol and/or drug abuse as evidenced by continued inability to maintain abstinence despite recent professional outpatient intervention.

If the patient has not been in a recent outpatient program (i.e., the past 3 months), then the following conditions must be met: 1) patient must be residing in a severely dysfunctional living environment; or 2) there must be actual evidence for, or clear and reasonable inference of serious imminent physical harm to self or others directly attributable to the continued abuse of substances which would prohibit treatment in an outpatient setting.

3. For individuals with a history of repeated relapses and a treatment history involving multiple

treatment attempts, there must be documentation of the restorative potential for the proposed admission.

B. Intensity of Service.

Due to significant impairment in social, familial, scholastic or occupational functioning, the individual requires intensive individual, group, and family education and therapy in an inpatient rehabilitative setting.

II. CRITERIA FOR CONTINUED STAY

In addition to meeting all of the admission criteria on a daily, continued basis, there must be daily documentation supporting the need for continued inpatient treatment. All of A through C below need to be met.

A. Progress Notes - Daily documenting of the providers' treatment, the patient's response to treatment, and the persistence of the problems that necessitated the admission, despite treatment efforts, or the emergence of additional problems consistent with the admission criteria.

B. The persistence of the problems that caused the admission to the degree that would necessitate continued inpatient care, despite therapeutic efforts, or the emergence of additional problems consistent with the admission criteria and to the degree that would necessitate continued inpatient care.

C. Clear and reasonable evidence that re-entry into the community would result in exacerbation of the illness to the degree that would require an inpatient level of care.

CRITERIA FOR ADMISSION AND LENGTH OF STAY FOR ALCOHOL/DRUG DETOXIFICATION AND AN INPATIENT SETTING

Patient must meet both of the criteria under the appropriate section.

I. CRITERIA FOR ADMISSION

A. Patient has a history of heavy and continuous alcohol/drug use requiring detoxification services where (a) there is the potential for serious physical harm from the side effects of withdrawal and (b) these services cannot be provided on an outpatient basis. Services that cannot be provided on an outpatient basis must require intensive nursing and medical treatment intervention on a 24-hour basis in order to be medically necessary on an inpatient basis.

B. Patient presents signs and symptoms of impending withdrawal and/or history of seizures of delirium tremens and requires intensive nursing and medical treatment intervention on a 24-hour basis.

II. CRITERIA FOR CONTINUED STAY

A. Documentation of the need for skilled observation and medical treatment consistent with AEP criteria.

B. Documentation of physical signs and symptoms of acute withdrawal which require intensive nursing and medical treatment intervention on a 24-hour basis. This documentation must be noted three times daily, of which one such notation must be made by a physician.

III. CONDITIONS LIKELY AND UNLIKELY TO BE RELATED TO TRAUMA OR WORK

The following classes of disorders are frequently diagnosed post-trauma:

A. Cognitive Mental Disorders.

Cognitive mental disorders associated with Axis III physical disorders - (mainly deliriums, but occasional dementias).

B. Mood Disorders.

Depressive Disorders NOS
Major Depression (all types)

C. Anxiety Disorders.

Panic Disorder (with or without Agoraphobia)
Agoraphobia without Panic
Specific Phobia
Post-Traumatic Stress Disorder
Generalized Anxiety Disorder
Anxiety Disorder NOS
Acute Stress disorder
Anxiety due to a (compensable) general medical condition

D. Somatoform Disorders

Conversion Disorders
Pain Disorders (all types, if pain secondary to a compensable injury)

E. Adjustment Disorders (all types) (note: reaction lasts no more than six (6) months)

F. Psychotic Disorders NOS
Brief Psychotic Disorder
Psychotic disorder due to a compensable general medical condition

The following classes of disorders are rarely post-trauma and in the committee's opinion are not caused or worsened by industrial injuries, diseases, or stresses.

A. Organic Mental Disorders.

Dementias arising in the senium and presenium, like Alzheimer's.
Multi-infarct dementia.

Psychoactive substance-induced organic mental disorders.

Alcohol (intoxication, idiosyncratic intoxication, uncomplicated alcohol withdrawal, withdrawal delirium, hallucinosis, amnestic disorder, dementia associated with alcoholism)

Amphetamine (intoxication, withdrawal, delirium, delusional disorder)

Caffeine (intoxication)

Cannabis (intoxication, delusional disorder)

Cocaine (intoxication, withdrawal, delirium, delusional disorder)

\+ Hallucinogen (hallucinosis; delusional, mood, or post hallucinogen perception disorders)

\+ Inhalant (intoxication)

Nicotine (withdrawal)

* Opioid (intoxication, withdrawal)

Phencyclidine (PCP) (intoxication, delirium; delusional mood or organic mental disorders)

* Sedative, hypnotic or anxiolytic (intoxication, withdrawal, withdrawal delirium, amnestic disorder)

* Other or unspecified psychoactive substance (intoxication, withdrawal, delirium, dementia, hallucinosis; delusional, mood, anxiety, personality, or organic mental disorders)

B. Psychoactive Substance Use Disorders.

Alcohol (dependence, abuse)

Amphetamine (dependence, abuse)

Cannabis (dependence, abuse)

Cocaine (dependence, abuse)

Hallucinogen (dependence, abuse)

Inhalant (dependence, abuse)

Nicotine (dependence)

* Opioid (dependence, abuse)

Phencyclidine (PCP) (dependence, abuse)

* Sedative, Hypnotic or Anxiolytic (dependence, abuse)

Polysubstance dependence

Psychoactive substance dependence or abuse NOS

\+ = compensable if an industrial agent exposure occurs at worksite.

* = compensable if iatrogenic via treatment for compensable injury.

C. Schizophrenia (catatonic, disorganized, paranoid, undifferentiated, residual).

D. Delusional (Paranoid) Disorder (erotomanic, grandiose, jealous, persecutory, somatic, unspecified)

E. Psychotic Disorders Not Elsewhere Classified
Schizophreniform disorders
Schizoaffective disorders
Induced (shared) psychotic disorder

F. Mood Disorders
Bipolar disorders (Mixed, Manic, Depressed)
Dysthymic Disorder (all types)

G. Anxiety Disorders
Social Phobia
Obsessive Compulsive Disorder

H. Somatoform Disorders
Body Dysmorphic Disorder
Somatization Disorder
Hypochondriasis

I. All Dissociative Disorders

J. Sexual Disorders

All sexual dysfunctions (unless caused by a physical disorder caused by a work injury, or psychogenic only secondary to work stress, disease or injury). Not compensable if lifelong or acquired through other than compensable means.

Sexual disorder NOS

K. Sleep Disorders, all types, - unless there is an organic factor related to the compensable injury.

L. Factitious Disorders, (all types)

M. Impulse Control Disorders Not Elsewhere Classified

Intermittent Explosive Disorder
Kleptomania
Pathological Gambling
Pyromania
Trichotillomania
Impulse Control Disorder NOS

N. V Codes for Conditions Not Attributable to a Mental Disorder that are a Focus of Attention or Treatment.

Academic Problem
Adult Antisocial Behavior
Borderline Intellectual Functioning
Childhood or Adolescent Antisocial Behavior
Malingering
Marital Problem
Parent-Child Problem
Other Interpersonal Problem
Other Specified Family Circumstances
Phase of Life or Other Life Circumstances Problem
Uncomplicated Bereavement

O. Disorders Usually First Evidence in Infancy, Childhood, or Adolescence as defined in DSM-IV Classification

P. All Personality Disorders

UTILIZATION REVIEW CRITERIA

OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT PROTOCOL

Mental health and substance abuse outpatient services are defined as partial hospital, intensive outpatient programs, outpatient therapy, and all other noninpatient treatment. The criteria contained in this protocol have been developed for outpatient mental health and substance abuse services that are less intensive than partial hospitalization or intensive specialty outpatient treatment programs.

Outpatient treatment protocols are based on both necessity of care and treatment approach. Outpatient treatment is based on Severity of Illness (SI) and Intensity of Service (IS) indicators. Patients must have psychiatric and/or substance abuse disorders with appropriate Severity of Illness and Intensity of Service indicators for outpatient treatment to be determined to be medically necessary.

Medical necessity is defined as follows:

"Services and supplies by a provider to identify or treat an illness that has been diagnosed. They are:

a. consistent with:
(1) the diagnosis and treatment of a condition; and
(2) standards of good medical practice;
b. required for other than convenience; and
c. the most appropriate supply or level of service."

The following criteria are a more detailed elaboration of the above definition for the purpose of establishing the medical necessity of outpatient mental health services.

1. The method of treatment specified in terms of treatment framework or orientation, treatment modality, treatment frequency, and estimate of treatment duration;

2. provision of measurable, target criteria for interim goals and end of treatment goals to be used to determine both that 1) treatment is progressing and 2) when treatment is no longer indicated; and

3. an alternative plan to be implemented if patient does not make substantial progress toward the given goals in a specified period of time. Examples of an alternative plan are a second opinion or introduction or adjunctive or alternative therapies.

CONTINUED OUTPATIENT TREATMENT CRITERIA

After initial treatment has been completed (GAF=70), continued psychotherapy treatment is indicated only if criteria below are met.

I. Severity of Illness Indicators

Continued outpatient psychotherapy treatment requires the presence of each of the following Severity of Illness Indicators:

A. A DSM IV diagnosis on Axis I.

B. A description of DSM-IV psychiatric symptoms, behavioral (occupational) and/or cognitive dysfunction, consistent with the diagnoses given; and

C. Impairment in occupational functioning due to those psychiatric symptoms. To address medical necessity in the context of varying patient needs, this impairment in functioning is divided into two subcategories.

1. Patients in the middle phases of treatment (six one-hour sessions over six weeks) who typically have fluctuating degress of impairments in functioning as evidenced by a specific clinical description. GAF scores, fluctuate but may exceed 71 for the six-week period prior to review. Such scores are frequently considered typical and appropriate within the context of the progressive response to treatment and the treatment plan.

Among the factors considered in making a determination on the continued medical necessity of treatment in this phase are the frequency and severity of previous relapses, level of stressors, and other relevant clinical indicators.

2. Patients in the final and consolidation phases of treatment (six one-hour sessions over twelve weeks) who typically have GAF scores above 71. Such scores are frequently considered typical and appropriate within the context of the progressive response to treatment and the treatment plan.

However, if the level of functioning has progressed to the point that the patient has sustained a GAF score above 71, serious consideration should be given to the medical necessity of continued treatment. Options to consider are: a) termination of treatment or b) reduction in the level and/or type of treatment previously given.

Note: Medication management with a visit every eight weeks for 15-20 minutes may be necessary indefinitely and should be reviewed on a case-to-case basis.

As above, the factors considered in making a determination about the continued medical necessity of treatment in this phase are the frequency and severity of previous relapse, level of stressors, and other relevant clinical indicators. The therapist should be able to explain whether the therapeutic modality being utilized will shift (and if not, why) when there has been sustained improvement as measured in part by a GAF score over 71.

II. Intensity of Services Indicators

Continued outpatient psychotherapy treatment requires the presence of each of the following indicators.

A. An update of the medically necessary and appropriate treatment plan specific to the patient's impairment in functioning and DSM-IV psychiatric symptoms, behavior or cognitive dysfunctions.

B. The treatment plan update must identify:

1. all changes in target specific DSM-IV psychiatric symptoms, behavior, and cognitive dysfunction being treated;

2. all modifications, if any, in biologic, behavioral, psychodynamic or psychosocial framework(s) of treatment for each psychiatric symptom/cluster and/or behavior;

3. all changes in the specific and measurable goals for treatment specified in terms of symptom alleviation, behavioral change, cognitive alteration, psychodynamic change, or improvement in occupational functioning;

4. all modifications in treatment methods in terms of:

- . treatment framework or orientation,
- . treatment modality,
- . treatment frequency, and
- . estimate of treatment duration;

5. progress in measurable, target criteria used to identify both interim treatment goals and end of treatment goals to determine 1) treatment is progressing and 2) goals have been met and treatment is no longer needed;

6. alternative plan to be implemented if patient does not make substantial progress toward the given goals in a specified period of time. Examples of an alternative plan are a second opinion or introduction of adjunctive or alternative therapies.

ADULT PSYCHIATRIC PARTIAL HOSPITALIZATION CRITERIA

Preamble - Medical necessity is defined as "services and supplies by a provider to identify or treat an illness that has been diagnosed or suspected. They are:

a. consistent with:
(1) the diagnosis and treatment of a condition; and
(2) standards of good medical practice;
b. required for other than convenience; and
c. the most appropriate supply or level of service.

When applied to inpatient care, the term means: "the needed care cannot be safely given on other than an inpatient basis."

The purpose of this protocol is to define and clarify criteria for when partial hospitalization for psychiatric treatment meets the above definition for medical necessity.

PRINCIPLES FOR CERTIFICATION

When a patient has a psychiatric disorder that requires professional evaluation and treatment, he/she should be treated at the least intensive outpatient level appropriate for the condition prior to partial hospital/day treatment; unless there is compelling evidence to the contrary.

I. Criteria for Admission

Medical necessity for psychiatric partial hospitalization treatment must be based on meeting the conditions defined under Section A, 1 and 2 (both must be met) and either 3 and 4, as well as meeting all of the criteria defined under Section B.

A. Severity of Need

1. Patient must have a mental illness. Mental illness is defined as Axis I psychiatric disorder that, by accepted medical standards, can be expected to improve

significantly through medically necessary treatment and therapy.

2. There is clinical evidence that documents that a less intensive outpatient setting is not appropriate at this time and/or a day treatment program can safely substitute for or shorten a hospital stay.

3. There is clinical evidence that the patient would be at risk to self or others if he were not in a partial hospitalization program. Additionally:

a. Patient can contract for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time; or

b. The patient is believed to be capable of controlling this behavior and/or seeking professional assistance or other support when not in the partial hospital setting.

4. As a result of the patient's mental disorder there is an inability to adequately care for one's physical needs, representing potential serious harm to self.

B. Intensity of Service

1. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours, and the patient must be capable of seeking them as needed.

2. The patient's condition must require intensive nursing and medical intervention for more than three (3) hours per day and for more than two (2) days per week.

3. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. A specific treatment goal of this team is improving symptoms and level of functioning enough to return the patient to a lesser level of care.

II. Criteria for Continued Stay

In addition to continuing to meet the criteria given above for admission, patients must meet A and B.

A. Progress notes for each day that patient is in a partial hospital/day treatment program documenting the provider's treatment, the patient's response to treatment, and the persistence of the problems that necessitated the admission to the partial hospitalization program, despite treatment efforts, or the emergence of additional problems consistent with the admission criteria.

B. Documentation that attempts at therapeutic re-entry into a less intensive level of care have or would result in exacerbation of the psychiatric illness to the degree that would warrant the continued need for partial hospitalization services.

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